THE Canadian Hospital

A Monthly Journal for Hospital Executives

Toronto, Can. **The Edwards Publishing Company** December, 1926

In This Issue—

To these products

KOTEX AND CELLUWIPES—two finished products of bulk Cellucotton

Cellucotton gives greater usefulness

ABSORBENT WADDING

—and hospitals find them equally indispensable

GREATER effectiveness—at lower cost—has made Cellucotton known as the most useful of all absorbents. Now, all its super-absorbency—all its greater economy, can be found in two Cellucotton products—Kotex and Celluwipes.

All the superior qualities of Cellucotton—and more! For these finished products also offer distinct, unique features of their own. Kotex pads, for instance, come ready-made—of Cellucotton wrapped in pure, fine Curity Gauze. Gone is the waste of time, of material, which hospitals inevitably suffer in the making of finished pads.

Patients find Kotex comfortable—nurses find it thoroughly absorbent, with an unusual ability to retain drainage. There are two sizes—ordinary thickness for average needs, and super-size for special thickness requirements.

Why is Cellucotton the most useful absorbent?

—because it absorbs from 4 to 8 times more drainage before saturation than most grades of absorbent cotton.

—because it retains more liquid before leakage takes place.

—because it absorbs 3 to 5 times as fast as absorbent cotton.

—because it draws fluid against gravity. It serves as a wick instead of a dam.

—because fluid penetrates to every part of the Cellucotton dressing.

—on account of its bulk, it makes more dressing per pound than absorbent cotton.

—because it is lighter, and more comfortable for the patient.

—because its cost is so low as to make it one of the most economical forms of absorbents.

To perfect their efficiency as wiping material, Celluwipes are specially calendered. Their necessary, uniform firmness results from that process—which is so devised that none of Cellucotton's super-absorbency is lost. Softer and much more absorbent than paper, Celluwipes are also more economical than most materials now in use. Made from single layers of Cellucotton, cut 6 x 5 inches, they are remarkably easy to use.

To hospital executives who wish to try either of these products—or bulk Cellucotton—we shall gladly send generous samples. Experiment with them in your own dressings room.

NOTE: Cellucotton's success has naturally been followed by substitutes. So, when buying, insist on genuine Cellucotton. It comes wrapped in blue, easily-identified paper, stamped with the trade-marked name "Cellucotton".

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Please refer to THE CANADIAN HOSPITAL when writing

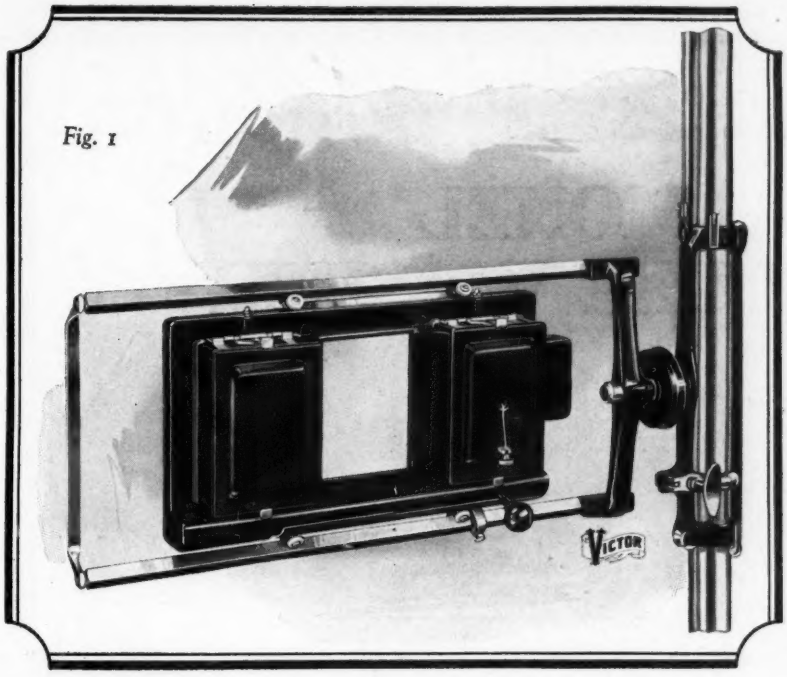

Fig. 1

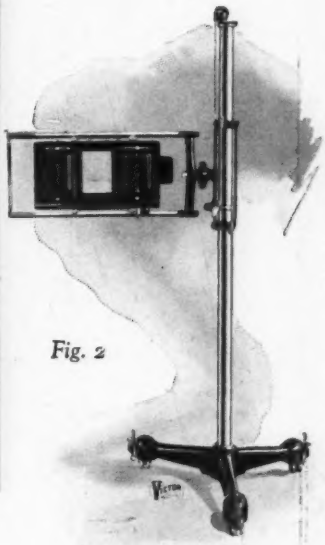

Fig. 2

Roentgenologists Have Long Awaited This

The Victor Serial Radiographic and Fluoroscopic Unit

Makes radiographic records of your observations during the fluoroscopic examination

A NATIONALLY known roentgenologist, after using this device for several weeks, writes:

"For many years roentgenologists have wished for an apparatus that would make a roentgenogram of exactly the thing that they were able to see, and this new device will certainly accomplish this. Your engineers have certainly thought of everything within reason and I consider it one of the most useful and perfectly constructed apparatus that I have ever seen. It will certainly be a great addition to our equipment."

The bulky, unwieldy serial radiographic device is now a thing of the past. It is superseded by this Victor Unit, the compactness of which, together with its flexibility and ease of manipulation, appeal to every operator.

Referring to Figure 1, the fluoroscopic screen carrier has mounted on it also two magazines, one on each side of the screen. The magazine at the right of the fluoroscopic screen holds six 5 x 7 cassettes with films and intensifying screens. During a fluoroscopic examination the operator may at any moment desire a radiograph of a certain pathology observed. He then needs only to grasp the knob at the lower right, and shift it over to the first notch to the left (which brings one of the cassettes into position behind the fluoroscopic screen), steps on the button of the floor switch to energize the tube for the radiographic exposure, then shifts the knob over to the extreme left in order to deposit the cassette in the magazine on the left of the fluoroscopic screen. The knob is now shifted back to its original position on the right, and the fluoroscopic examination is resumed until observation calls for another radiographic exposure, when the above procedure is repeated.

This is accomplished without loss of time, and without the operator moving away from his position in front of the fluoroscopic screen. A two-button floor switch gives him selection between fluoroscopic and radiographic currents. At his arm's reach is also a small control stand (auxiliary to the regular auto-transformer control on the X-Ray machine) thru which he may vary the penetration as required during fluoroscopic examination, also control the Coolidge filament circuit to vary the fluoroscopic milliampereage.

Figure 2 shows the Unit proper mounted on floor stand. The complete rotation of the horizontal arm by means of its swivel attachment to the vertical column, permits of any angular position required in either radiography or fluoroscopy. Vertical adjustment is quickly and conveniently made thru a counterweight suspended by wire cable in the vertical tube column, and operating over the swivel pulley at the top. Note the conspicuous absence of electrical parts or wires to be avoided by patient and operator.

Its range of usefulness. Practically every specialized laboratory will realize its advantages in almost every phase of fluoroscopic diagnosis. Consider its value in the radiography of nervous children especially, where locating the area and positioning of the part are difficult before the radiograph is made. The fluoroscopic screen may be here resorted to, then the radiograph made instantly—no need of moving the patient over to another radiographic unit. In fracture cases, too, it suggests itself in many ways. Finally, in serial radiography of the stomach it serves ideally, answering every possible requirement in the most practical and efficient way.

Complete description sent on request

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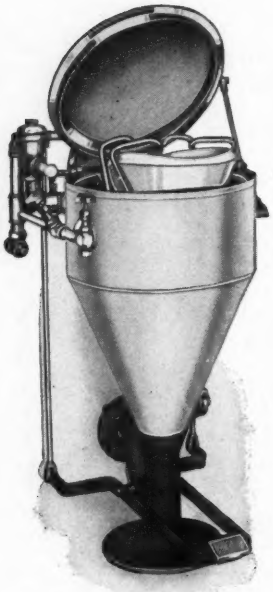
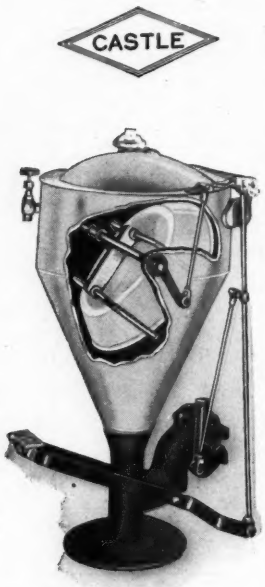
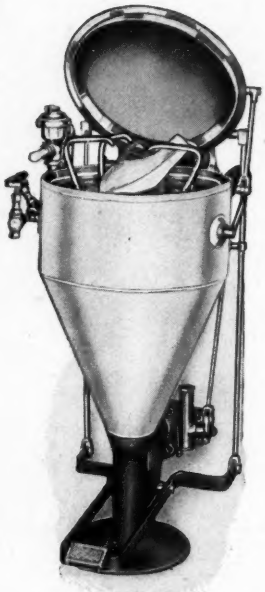
New Castle Bed Pan Washer Actually Cleans and Sterilizes



Pressing foot pedal prepares Washer to receive bed pan.



Releasing foot pedal empties pan and seals Washer.



Washer may be used for urinals, or any size bed pan.

Supporting arms force water and then steam against all surfaces

It is not an overstatement to say that the new Castle Bed Pan Washer is nearly 100% effective in washing and sterilizing bed pans and urinals.

Its new and patented method of forcing several high pressure water and steam jets against *all* inner surfaces puts it in a class by itself for high efficiency.

Nozzles point at different angles

This is the only washer which projects water and steam underneath the lip of the pan in several different directions. It is the only washer utilizing the supporting arms to conduct this complete washing.

Self Cleansing

Furthermore, the inside of the washer itself is automatically self cleansing. Raising the cover opens a valve that wets all inner surfaces. Thus, when the pan is emptied, there is no adhesion of material. This also automatically fills a water seal that prevents escape of odors.

Finally in operation a Sloan flush valve deluges the pan and interior of washer with ten gallons of water—a final and complete flushing action.

Foot pedal instead of hand crank

The pan is automatically emptied when the cover is lowered and raised when the cover is opened. A foot pedal does this—no hand crank is necessary.

Send for new booklet on Bed Pan Washers and Blanket and Solution Warmers

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Tax on Meals Successful

The job of increasing hospital revenue and obtaining financial aid from every possible source is, and perhaps always will be, the chief concern of the average hospital financial executive.

New methods of raising funds are therefore a matter of deep interest to all hospital workers. One of the most successful of schemes was inaugurated this year by the Province of Quebec in their tax on meals served in restaurants and hotels.

Estimates of the revenues to be gathered for the benefit of hospitals from the new tax which was created at the last session of the Legislature, tend to show that the first year of operation of the new tax will bring in nearly $500,000. This is said to be very satisfactory. There are rumors that the meal tax will be extended to meals served on trains and boats and in clubs.

Sprinkler Systems Often Economical

The advantages of the sprinkler system for fire control are, in many cases, so apparent that it is to be wondered why more hospital properties are not covered by this form of protection.

After considering the greater safety of the patients in sprinklered institutions, which is after all, the main consideration, there is also a large monetary saving involved.

In the case of sprinklered hospitals carrying fire insurance based on 90 per cent. of valuation or more, there is usually a big saving in premiums which more than offsets the carrying charges on the installation of the sprinkler system.

We have in mind a hospital in one of the Maritime Provinces which is insured for $200,000. With sprinkler installation this would be dropped to $165,000, or 90 per cent. of the indestructible portion of the building and contents. The saving in lower premiums, on less insurance, in this instance would amount to about $34,000 over a fifteen-year period.

The amount of saving will vary according to the percentage of insurance carried, the condition of buildings, location and other considerations, on all of which the advice of a fire insurance expert is necessary.

Urges Better Treatment of Nurses

"In my opinion, the nursing profession is at a critical point," said Prof. Lyle Cummins, of the University of Cardiff, Wales, addressing the Ontario Hospitals Association in October.

"There are many avenues to-day for the woman seeking employment. Nursing must be made more attractive to get the proper type of recruits for the profession. We find in England that it is not so easy to secure attendant nurses as it once was. Not by trade-union methods, but by the creation of public opinion, I believe, you should see to it that nurses secure proper salaries. In addition, there should be provision for old age. There should be a system of pensions whereby the nurse who has grown old in her profession will not want after her usefulness is over."

Attractive Reports Good Publicity

A copy of the Annual Report of the Royal Alexandra Hospital, Edmonton, has been received by the Editor and we wish to compliment those responsible for the excellent way in which it is presented.

The cover is printed with dark brown ink on heavy white grained stock, the inside with brown ink on white coated paper. At the top of each page is the name of the Hospital in Old English type centred in a scroll with the Hospital's crest.

Complete information for the guidance of the public is given, such as charges for rooms, operating room fees, etc. Following this is published the names of those comprising the Board of Directors for the year, committees of the Board and the Hospital staff.

The reports of the various departments come next. These are all models of brevity, yet apparently nothing of importance has been omitted. After the balance sheet is taken care of, a section is devoted to the Training School for Nurses.

Throughout the booklet of twenty-eight pages and cover, illustrations of the Hospital, exterior and interior, are interspersed, the whole making a "Report" so attractive in appearance that it should help materially to make better known the complete facilities available to the people in the community served by this thoroughly modern Hospital.

Why not make your next annual report not merely a dry statement of facts, but an advertisement of real value to your hospital?

Reasons for "Closed Door" Hospitals

In an interview recently in Montreal, Dr. Allan Craig, associate director of the American College of Surgeons, presented arguments in favor of the hospital's right to give credentials to those physicians who are to be accorded its privileges. "It has been fairly well established in courts of law that the hospital as a body is to a certain extent responsible for the professional activities of the members of its staff," Doctor Craig stated. "This being the case, it is only just that the institution should have the right to approve members of its staff and say who shall or shall not be accorded its privileges. The fact that a physician is a graduate from a medical school, that he is licensed to practise within a province or state, does not, at the same time, license him to practise in any hospital within that province or state. The state exercises a selective function, and why should the hospital not have a similar right? In case of legal difficulty because of unfortunate or incompetent practice, the hospital can only protect itself by showing evidence that means have been taken to assure the directors of the institution of the competency of the staff members before they were accorded the privileges of the hospital. Up to the point of establishing reasonable precautions as to the competency of its staff, the institution, along with the individual physician or surgeon, may be held responsible.

"There are three distinct types of institutions when considered in relation to staff privileges.

"1—The closed hospital, the entire privileges of which are limited to a certain group of medical men. These hospitals are often private institutions or those controlled by universities for teaching purposes.

"2—There is the hospital which permits any practitioner of medicine without question, the privileges of its various wards and services. Such hospitals as a rule have no organized staff, and both private and charity cases are treated by any physician in the community. Such institutions are not capable of meeting the minimum standard, and because of lack of uniformity in practice and the impossibility of checking up results their patients are not assured of the best modern medical care and treatment.

"3—There is the hospital which as a corporate body reserves the right to give credentials to those physicians desiring to practise within its confines."

Doctor Craig made it plain that he was not in favor of hard and fast requirements for staff appointments, or staff promotions which are so rigid as to discourage good men, not only for hospital privileges but also from advancement after they have been appointed. The first consideration is the welfare of the patient, and the best doctor should always have a chance.

New Color Schemes Effective

Adoption of a new color scheme has made St. John's Hospital in Shepherd's Bush the cheeriest of hospitals in London, Eng.

The secretary and matron say that Mr. Walsh's ideas that restful, health-giving colors should replace white walls and red coverlets has been carried out by them with excellent results. Delicate shades of green, yellow and mauve in the wards, worked out by a color expert, have proved so beneficial that patients leave the hospital three days sooner than before the change was made. Their tempers are better, the colors influence sleep and in one case, after placing an insomnia patient into a mauve room, sleep came within an hour, the officials said.

St. Mary's Hospital Extends

St. Mary's Hospital, Toronto, situated at the north-west corner of Jarvis and Isabella Streets, until recently was strictly an obstetrical Hospital. In view of the growing demand for hospital accommodation, the Sisters of Miséricorde, in charge of the Hospital, have decided to make it a "General Hospital" and while continuing to feature obstetrical and gynecological work, all medical and surgical cases, except those of a contagious or infectious nature, will be accepted.

There are no public wards in the Hospital, the beds all being private and semi-private. The rates are from $3.00 to $7.00 per day. Any physician and surgeon is privileged to attend his cases there.

It is only the great man who appears to know how to do the smallest thing with thoroughness.

ALBERTA HOSPITALS PRESENT THEIR CASE

The Province of Alberta, through the Department of Public Health, allows the recognized hospitals of the Province a grant of 50c. per patient per day.

We might ask in the first place, "Why this grant?" What is the purpose for which it is given the hospitals? We have been informed on previous occasions that the purpose of this grant originally was to compensate the hospital for the transient indigent who was admitted to hospitals. If that interpretation is correct, the 50c. per patient per day would, of course, cover it, but we contend that the Province as a whole has a greater responsibility in hospital matters than that. The general care of the sick is as much a Provincial matter as it is a local one, and on that basis we claim that the Province, through the Government, should accept their full share of the maintenance of hospitals for the sick people of the Province. We do not think the 50c. per day is sufficient to meet the responsibility.

In addition to this, hospital charges are always, of necessity, set below actual cost. It is a matter of impossibility to burden the individual patient by charging what the service actually costs the hospitals, and we think the grant should be given for the purpose amongst others, of helping the hospitals to meet this difference between actual cost and the rate charged.

A Comparison

For the sake of comparison we would like to place before this Commission particulars of what is done for hospitals by the Governments of the neighboring Provinces of Saskatchewan and British Columbia, viz:

(a) Saskatchewan is much the same as Alberta. That is, the Government pays 50c. per patient per day to each hospital. But there is this vital difference: In Saskatchewan the Government pays for the day of admission and for the day of discharge, and any patient who enters and leaves the hospital on the same day is recognized as one day for the purpose of the Government grant.

(b) British Columbia affords a striking example of generous treatment to hospitals. Their grant is based on a sliding scale as follows:

For the first 1,000 days	$1.00 per day.
For the next 1,500 days	70 per day.
For the next 2,500 days	.55 per day.
For the next 5,000 days	.50 per day.
and afterwards at the rate of	.45 per day.

Under the British Columbia plan the smaller hospitals, of course, receive a greater benefit than the larger ones, but in addition to this grant, 15 per cent. of the profits from the sale of liquor is distributed amongst the hospitals up to a rate not exceeding 25c. per patient per day. Even taking the lowest rate of 45c. per day under the sliding scale, this extra allowance from the liquor profits exceeds the per capita allowance paid to hospitals by the Alberta Government.

In British Columbia also, when a patient enters a hospital from an outside municipality, that municipality has to pay to the hospital a rate of 70c. per day. This has no connection whatever with the individual charge to the patient, but it is on the basis of the municipality's contribution to the support of the hospital, and has also been brought into effect to absolutely eliminate the vexatious questions of a municipality's responsibility for indigent hospital patients.

Here again in British Columbia, when calculating the number of days for the grant, both the day of admission and the day of discharge are counted, and the Government also pays one day for the patient who enters and leaves the hospital on the same day.

A special grant is made in British Columbia of $1.00 per patient per day for pulmonary tuberculosis patients.

Pay for Whole Period

We wish to ask your very special consideration to the point of not paying a grant for both the day of admission and the day of discharge, and of thus eliminating altogether the patient who leaves the hospital the same day as he enters it. Prior to the year 1923, by definite government instructions, when calculating the number of days, admission and discharge days were reckoned, and from the origin of the grant until that time, hospitals were paid accordingly. After two or three months of the year 1923 had elapsed without any prior notice, the hospitals were informed that in future the day of discharge had not to be counted, so that one day was taken off each patient, and the patient in for one day only not recognized at all. That new ruling was to apply to that current year, after hospitals has compiled their budgets and arranged their finances. That really meant a reduction in the grant. The smaller hospitals of the Province, under this ruling, have lost from $500.00 to $1,000.00 per year; and the larger city hospitals anything from $3,000 to $5,000 per year. A patient comes in now in the early morning of one day, he leaves late in the evening of the next day, and we are allowed only one day. Other cases, such as tonsils, teeth extractions, and many minor surgical cases, come into the hospital. They occupy a bed for the day, are given all the nursing facilities the same as any other patient. For that one day they are as costly to the hospital as any other patient, and yet we are not allowed to include them in our returns for the grant. If the principle of the grant is a recognized one, we cannot see any justification for such a restriction as this.

One of the grievous problems in city hospital finances is the non-payment for patients from outside municipalities. Onus is placed on the hospital to prove the indigency of the patient. In only a few cases will the municipalities recognize the hospitals' claim. Figures prepared by the Alberta Hospital Association show that in one year only 25 per cent. of the hospitals' accounts against muni-

Submitted to the Taxation Commission of the Alberta Provincial Government by the Executive Committee of the Alberta Hospital Association, Edmonton, Sept., 1926.

cipalities for indigents was paid. In addition to this difficulty, the Act limits the payment of the municipality to a maximum of $200.00. Every hospital can show records of indigent patients from municipalities whose indebtedness has doubled and trebled that amount, and in many cases it has been found impossible to collect even the $200.00. At this present critical period in the crop season, patients are entering our hospitals from municipalities without money, depending upon their crop returns to enable them to ultimately pay. It simply means that the hospitals have to finance these people and take their chance of payment out of doubtful crop returns. You will notice British Columbia overcomes this by placing a financial responsibility on municipalities for each and every patient admitted from their territory.

Costs Cannot be Lowered

From information that we have available it would appear an impossibility to make any reduction in the daily cost of hospital operation. The leading hospitals vary little in this respect, averaging from $3.50 to $4.00 per patient per day. The tendency is for this to increase. Hospital service is continually progressing. New demands are being made consistent with advancement in medical science and new discoveries. Laboratory work, x-ray service, high standards of operating service, new equipment such as electrical apparatus, etc., are being demanded, and adding to cost. The Provincial Government is continually endeavouring to raise the standards of our hospitals with a view to affecting the maximum of protection to the individual patient. This cannot be done without increasing expenditures, but no additional assistance has been forthcoming from the Government. It is useless to endeavour to meet this condition by an increase in the daily charge to the patient. As an Association, our view is that the burden on the individual should be lightened. At present about 25 per cent. of the revenue earned by hospitals is uncollectable. The hospitals under present conditions could only help themselves financially by refusing admission to those who cannot pay. But this is never done. We believe it is most inadvisable to endeavour to meet increasing deficits by increasing our daily rates, and are of the opinion it is now time for hospital maintenance to be distributed to a greater extent amongst all the people.

Our deficits at present have to be made good by demands on the cities. In Calgary last year the City had to provide more than $140,000.00 for hospital purposes. The Hospital received from the Government by way of grant, $29,000.00. In Edmonton, for the Royal Alexandra and Isolation Hospitals, the City provided $66,000.00 and the Government $40,000.00. In the smaller hospitals, such as Lethbridge and Medicine Hat, the cities and other outside contributions amount to about $12,000.00 annually with a Government grant averaging $9,000.00.

The modern isolation hospital has come to be recognized as a very important factor in the work of preventive medicine, inasmuch as by receiving patients from trains, boarding houses, hotels, universities and other public places, they minimize the chance of the contagion spreading. The same is true also of the family of small children in which one member develops some contagious disease. In many cases when the one is removed promptly to an isolation hospital the others are prevented from developing the disease. Also by removing the necessity of quarantine from these public places and private homes, they allow the institution or the home to carry on without any serious handicap as would be the case if they were quarantined there and isolated for the necessary period as prescribed by law.

Whereas 1: Many patients who develop contagious diseases are young growing children whose parents can ill afford to bear the increased cost of proper care and treatment and who if they do, deprive themselves and families of other necessities.

Whereas 2: Many transients, many of whom are immigrants, for whom no municipality is really responsible, are treated in the isolation hospitals.

Whereas 3: The work of the isolation hospital is a very important factor in the work of preventive medicine and is of great benefit to the Province as a whole.

Whereas 4: Under present conditions the cost of erecting and maintaining these institutions has been borne by two municipalities in this Province except for the grant of 50c. per day made by the Provincial Government.

Whereas 5: A large and increasing number of immigrants are annually coming to Alberta for whose care no municipality or Government is responsible in case of illness during the first three months of residence.

We would therefore submit that:

1. The Provincial Government should make a grant to isolation hospitals of at least $1.00 per day for all patients.

2. That the Provincial Government should be responsible for the isolation hospital accounts of all non-pay transients or immigrants, who have not been residents of any municipality for three continuous months. That the Health Act be amended so as to provide for compulsory vaccination for smallpox and for the use of preventive measures in all cases which are found to be susceptible to diphtheria.

4. That it be made compulsory for all cases of smallpox, scarlet fever and diphtheria to be treated in isolation hospitals.

Schools of Nursing

It is a well-known fact that originally schools of nursing were established with the object in view of providing care for the sick, who were housed in buildings known as hostels or hospitals. The young women so employed received very little, if any, teaching from the officers in charge of the hospital. There has been, however, through the years which followed, a very gradual change in the attitude of hospital executives towards students of nursing, until at the present time we find that there has been as a result of the work of the past, a well-

established method of conducting schools of nursing and so it is that to-day schools of nursing are, in every sense of the term, recognized as educational institutions in the same sense and to the same degree as are public and high schools, colleges, schools of technical education and universities; but while hospital executives and the public generally have come to so regard schools of nursing, it is quite evident that our Provincial Government does not so regard them, for while it makes an annual grant of approximately one million or more to public and high schools, it makes no grant whatsoever to schools of nursing in this Province. It is also a well-known fact that considerable assistance is given by the Government to medical education as carried on by the University of Alberta. There is in our opinion as hospital executives no good reason whatsoever for the Government withholding assistance from schools of nursing, which are so necessary to the welfare and well-being of the citizens generally throughout the Province.

It is being more and more impressed upon all hospital authorities that from year to year more of the nurses' time will have to be spent in the class-room and less on ward duty. This means that it will be necessary to employ more teachers, to provide more class-room accommodation and also to make provision for the housing of a larger number of students. The cost of operating a school of nursing in this Province is increasing steadily.

Whereas there are in the Province of Alberta 62 hospitals, all of whom receive a Government grant of 50c. per patient per day;

Whereas twelve of these hospitals conduct schools of nursing;

Whereas there were one hundred graduates of schools of nursing who passed the R.N. examinations at the University of Alberta in 1925;

Whereas these schools of nursing in this Province supply graduate nurses for private duty in homes and executive positions in hospitals and public health services;

Whereas the course given in these schools of nursing is an educational one;

Whereas the cost of conducting these schools of nursing has been borne by hospitals and indirectly by the taxes of the municipalities or as in some cases by private subscriptions;

Whereas the Educational Department of the Government pays large sums annually in the form of grants to public and high schools;

Whereas the Educational Department of the Government renders substantial assistance for the carrying on of an institution in which students are trained in the science of medicine and surgery;

Whereas the Government does not at the present time and has not in the past rendered any assistance whatsoever to schools of nursing in this province;

We therefore request that the Provincial Government be urged to make an annual grant to each approved school of nursing in this Province and that this grant be at least $300.00 for each graduate who passes the Registered Nurses' Examination as set by the University of Alberta.

MAKING THE SMALL LAUNDRY PAY PROFITS

BY J. J. WILLETT
Unity Union Hospital, Unity, Sask.

Does the laundry plant in a small hospital pay? You bet it does. It pays in the small hospital where there is an average of ten patients per day, and correspondingly greater profit is shown in the larger hospital in the small hospital class; that is an institution showing an average daily of twenty to forty-five patients. When we get into the medium-sized hospitals, those having one hundred beds or more, the showing is no less favourable except for the fact that the laundry workers are very often more highly trained, are paid better wages to do the one class of work and are not available to shift around the institution to do other work when the laundry work may have fallen off due to a slump in hospital attendance. In the large hospital of from 200 to 300 beds, there is no argument at all. To do without their own laundry plant entails the purchase of an enormous amount of linen, and the checking out and in of the linen as it goes to and fro to the custom laundry is expensive, not to mention the possibility of a shortage in your count due to the little mix-ups that occur in the best managed plants occasionally; and the possibility of that plant breaking down and leaving you on short linen rations for a few days.

Now, the main factors which make the installation of a laundry plant a success in a small hospital might be summed up as follows; a plentiful supply of good water, a high pressure steam boiler to heat the water and heat the laundry machinery, the proper machinery, good sewage disposal and competent WHITE help. Given these, and a systematic laying out of the work, the small laundry plant can not only be made to show a profit, but you will get more service from your linen, it will last longer; you have no chance to lost it except by downright theft, and you will experience a really wonderful feeling of independence in knowing that you may go down and crank up the engine or turn on the motor and wash to-day or to-morrow or even on Sunday if necessary.

Service is Important

If there is a good steam laundry in the same town in which the hospital is situated, it is possible to get a very close price from them sometimes and the margin would be so small that it might not pay to have your own plant. Laundries have to give good service to hold the trade, and they might give you a little whiter class of goods due to their consistent, timed-to-the-minute method of washing; a little better ironing due to their better-class flat work ironer, but they do not always give this service, and the linen does not stand up under their treatment as it does where the goods are separated and classified.

Here we sort our linen into four or five lots. Small stuff such as towels, pillow slips, binders, table napkins and the table cloths are put in one lot. The table cloths are put in this lot to ensure the same treatment and the same shade of blue as the table napkins. Then the sheets are sorted; all draw sheets in one lot and all large sheets in another. I find the draw sheets the hardest lot we have, while the large sheets are possibly the easiest. Bed spreads go in another lot and the downs in another. If there is not a very large lot of either of the last two, I put them both in the machine at once. The nursery clothes are washed separately, and sometimes we have to wash every day to keep a supply of them on hand; but the regular wash days are Tuesdays and Fridays. Yes, I have to wash on Sundays many a time to keep the nursery going.

(Continued on Page 19)

St. Vincent's Hospital
LOS ANGELES

A FAMOUS HOSPITAL WHERE D&G SUTURES ARE USED

Kalmerid Catgut

GERMICIDAL. Exerts a bactericidal action in the suture tract. Supersedes the older unstable iodized sutures. Impregnated with the double iodine compound, potassium-mercuric-iodide.† Heat sterilized.

The boilable grade is unusually flexible for boilable catgut; the non-boilable grade is extremely flexible.

TWO VARIETIES

BOILABLE* NO.		NON-BOILABLE NO.
1205	PLAIN CATGUT	1405
1225	10-DAY CHROMIC	1425
1245	20-DAY CHROMIC	1445
1285	40-DAY CHROMIC	1485

Sizes: 000..00..0..1..2..3..4

Approximately 60 inches in each tube

Package of 12 tubes of a size.....$3.00

Less 20% on gross or more or $28.80, net, a gross

Claustro-Thermal Catgut

ASEPTIC—not germicidal. Sterilized by heat after the tubes are sealed. Boilable.* Unusually flexible for boilable catgut.

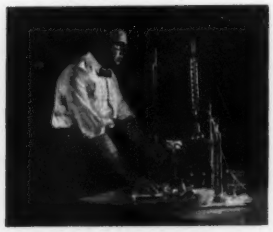
NO.	
105	PLAIN CATGUT
125	10-DAY CHROMIC CATGUT
145	20-DAY CHROMIC CATGUT
185	40-DAY CHROMIC CATGUT

Sizes: 000..00..0..1..2..3..4

Approximately 60 inches in each tube

Package of 12 tubes of a size.....$3.00

Less 20% on gross or more or $28.80, net, a gross

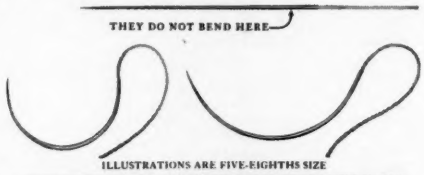


D&G Sutures are always found neutral under the most delicate titration tests. This is one of the reasons they uniformly behave well in the tissues.

Atraumatic Needles

FOR GASTRO-INTESTINAL suturing and for all membranes where minimized suture trauma is desirable. Integrally affixed to 20-day Kalmerid catgut. Boilable.*

Experimental evidence has proven 20-day chromic catgut the most suitable for gastro-intestinal suturing. It has been found that gastric wounds are fully healed within 12 days, and intestinal wounds at 16 days. At these periods the 20-day catgut (regardless of size) still retains, respectively, 60 per cent and 30 per cent of its initial strength.



ILLUSTRATIONS ARE FIVE-EIGHTHS SIZE

STRAIGHT NEEDLES ARE IN ROUND TUBES

CURVED NEEDLES ARE IN FLAT TUBES

NO.		INCHES IN TUBE	DOZEN
1341	STRAIGHT NEEDLE	28	$3.00
1342	TWO STRAIGHT NEEDLES	36	3.60
1343	⅜-CIRCLE NEEDLE	28	3.60
1345	½-CIRCLE NEEDLE	28	3.60

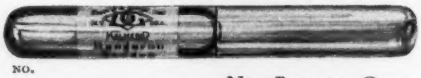
Less 20% discount on one gross or more

Sizes: 0 and 1

Packages of 12 tubes of one kind and size

Kangaroo Tendons

GERMICIDAL, being impregnated with potassium-mercuric-iodide.† Chromicized to resist absorption in fascia or in tendon for approximately thirty days. The non-boilable grade is extremely flexible.



NO.	
370	NON-BOILABLE GRADE
380	*BOILABLE GRADE

Sizes: 0..2..4..6..8..16..24

Each tube contains one tendon

Lengths vary from 12 to 20 inches

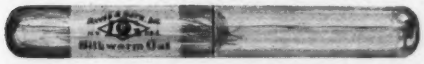
Package of 12 tubes of a size.....$3.00

Less 20% on gross or more or $28.80, net, a gross

DAVIS & GECK INC. ▾ 211-221 DUFFIELD ST. ▾ BROOKLYN, N.Y.

D&G Sutures are obtainable from responsible dealers everywhere; or direct, postpaid

Non-Absorbable Sutures



NO.		INCHES IN TUBE	SIZES
350	CELLULOID-LINEN	60	000, 00, 0
360	HORSEHAIR	168	00
390	WHITE SILKWORM GUT	84	00, 0, 1
400	BLACK SILKWORM GUT	84	00, 0, 1
450	WHITE TWISTED SILK	60	000 TO 3
460	BLACK TWISTED SILK	60	000, 0, 2
480	WHITE BRAIDED SILK	60	00, 0, 2, 4
490	BLACK BRAIDED SILK	60	00, 1, 4

BOILABLE

Package of 12 tubes of a size.....$3.00
Less 20% on gross or more or $28.80, net, a gross

Short Sutures for Minor Surgery

NO.		INCHES IN TUBE	SIZES
802	PLAIN KALMERID CATGUT	20	00, 0, 1, 2, 3
812	10-DAY KALMERID "	20	00, 0, 1, 2, 3
822	20-DAY KALMERID "	20	00, 0, 1, 2, 3
862	HORSEHAIR	56	00
872	WHITE SILKWORM GUT	28	0
882	WHITE TWISTED SILK	20	000, 0, 2
892	UMBILICAL TAPE	24	⅛-IN. WIDE

BOILABLE

Package of 12 tubes of a size.....$1.50
Less 20% on gross or more or $14.40, net, a gross

Emergency Sutures with Needles

UNIVERSAL NEEDLE FOR SKIN, MUSCLE, OR TENDON

NO.		INCHES IN TUBE	SIZES
904	PLAIN KALMERID CATGUT	20	00, 0, 1, 2, 3
914	10-DAY KALMERID "	20	00, 0, 1, 2, 3
924	20-DAY KALMERID "	20	00, 0, 1, 2, 3
964	HORSEHAIR	56	00
974	WHITE SILKWORM GUT	28	0
984	WHITE TWISTED SILK	20	000, 0, 2

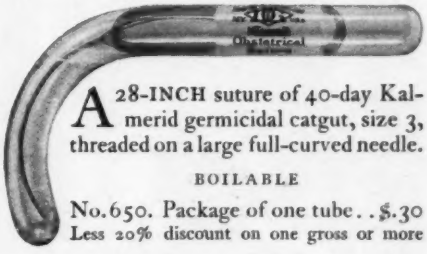
BOILABLE

Package of 12 tubes of a size.....$2.40
Less 20% on gross or more or $23.04, net, a gross

The ash of D&G Sutures is assayed to make sure that no traces remain of uncombined chromium nor of other residues of the chromicizing process.

Obstetrical Sutures

FOR IMMEDIATE REPAIR OF PERINEAL LACERATIONS



A 28-INCH suture of 40-day Kalmerid germicidal catgut, size 3, threaded on a large full-curved needle.

BOILABLE

No. 650. Package of one tube..$.30
Less 20% discount on one gross or more

Circumcision Sutures

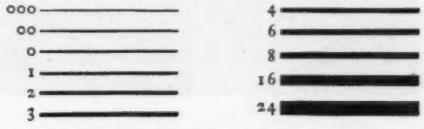
A 28-INCH suture of Kalmerid germicidal catgut, plain, size 00, threaded on a small full-curved needle.

BOILABLE

No. 600. Package of 12 tubes.....$3.00
Less 20% on gross or more or $28.80, net, a gross

Universal Suture Sizes

All sutures are gauged by the standard catgut sizes as here shown



*These tubes not only may be boiled but even may be autoclaved up to 30 pounds pressure, any number of times, without impairment of the sutures.

†Potassium-mercuric-iodide is the ideal bactericide for the preparation of germicidal sutures. It has a phenol coefficient of at least 1100; it is not precipitated by serum or other proteins; it is chemically stable—unlike iodine it does not break down under light and heat; it interferes in no way with the absorption of the sutures, and in the proportions used is free from irritating action on tissues.

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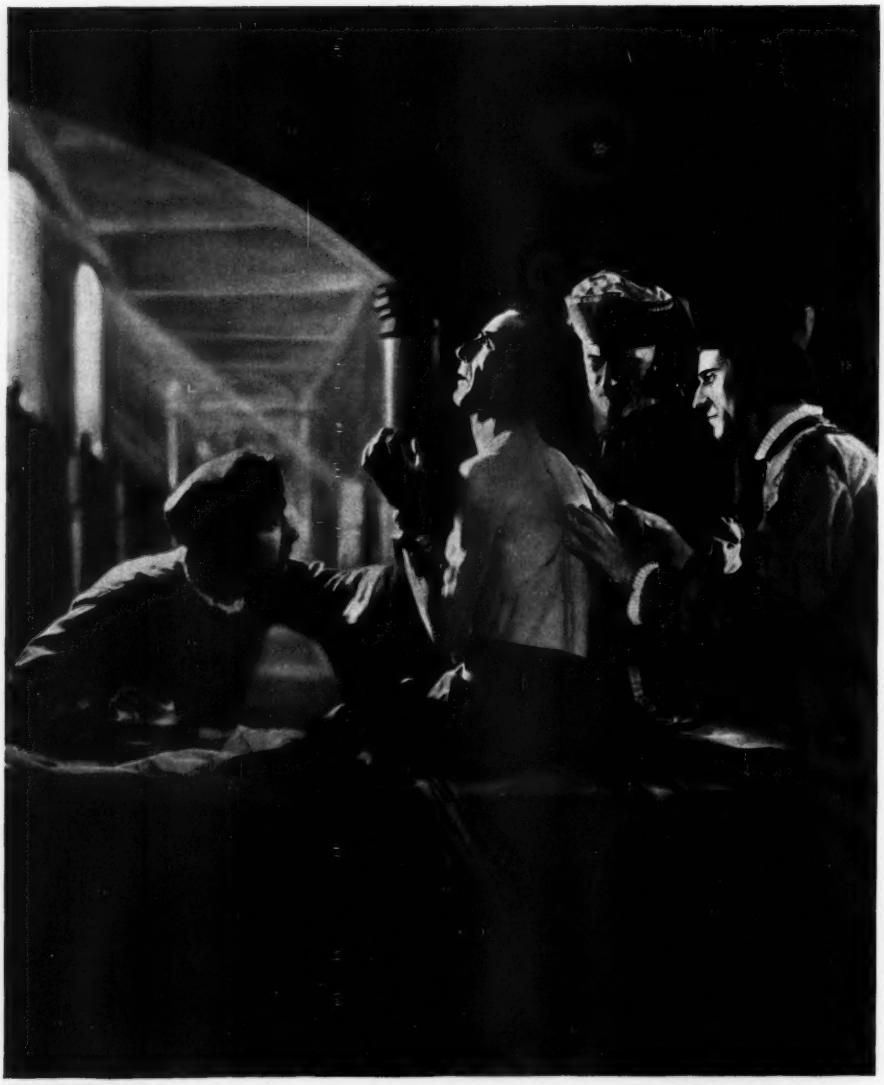

GUGLIELMO SALICETTI 1201-1277

The achievements of this distinguished Italian surgeon included the suturing of divided nerves. That even then considerable thought was given to suture material is shown by his comments on the relative merits of silk and waxed thread.

D&G Sutures

"THIS ONE THING WE DO"

DAVIS & GECK INC.

The small stuff is the first lot we wash, followed by the draw sheets, the big sheets, bed spreads and gowns, and on Tuesdays we wind up by washing the staff uniforms. While we generally have the first lot out before lunch the girls do not get through their kitchen and ward work till about 1.30, so that with the machinery running all through the noon hour, we have the second lot ready when they come in. This first lot is shook out—all towels in one pile, pillow slips in another, kitchen and operating towels in a third, and all others in a fourth. Kitchen and operating towels are ironed first so that operating towels are available for sterilizing while we have steam up. When the last pile is going through the ironer, is it usually fed on one side and draw sheets substituted on the other, as draw sheets can be just as easily fed by one girl as two. In this way both girls are occupied all the time, and the machine is kept up to capacity. The ironer is small, only one roll, but it does a lot of work. Heavy towels have to go through two to four times, sheets twice, bed spreads twice, and then hung up folded to dry. Gowns are put through only once and then hung up carefully, and they really look well ironed after such treatment. The belts and bibs from the staff wash are put through sizing and then ironed direct through the ironer. It gives a finish not possible by hand. Curtains are cold-sized and ironed on this machine.

Blankets come down in fairly large numbers, and as they are an expensive item when sent out to a laundry they are sometimes not washed as often under such conditions as they would be where you have your own plant.

The small hospital and its laundry plant may have this disadvantage; it is not always easy to get someone to manage the laundry plant who is willing and capable of adapting himself or herself to other work when the laundry has no demands on his or her time. To have special laundry help doing that work only, is not economical, for if they have machinery and they use it intelligently, it does not take long to do a large amount of work. Certainly not more than two or three days in the week. If it is a matter of running every day, then it ceases to be a small laundry in a small hospital. The ideal condition appears to be where the engineer or janitor can take care of the machinery and the washing process, and the ward maids and kitchen help handle the ironing machinery. Laundry processes are not as simple as they look, but with the helping hand of the service man from the laundry supply houses, a little study and application on the part of the operator, which includes the reading of a good laundry trade magazine, and the co-operation of other operators in the hospital laundry field, there is no reason why any hospital should be denied the convenience of their own plant, and that plant operated by WHITE help.

In conclusion, the laundry costs here at this hospital have been cut from over $1,800.00 per year to less than $75.00 the first year; $122.00 the second year and slightly higher for 1926, possibly $315.00. This increased cost is due to increased hospital attendance.

DIETETICS

The Place of the Dietitian in the Hospital

By EDNA W. PARK
Department of Household Science
University of Toronto

One of the most important duties of the hospital dietitian is the planning of meals that are nourishing, appetizing and at the same time economical for the nurses and the hospital staff, and it is the economic factor that so limits institutional dietaries as to prevent them being adequate from the nutritional standpoint.

In all too many hospitals the dietitian is urged to keep food costs down to the minimum and so she is frequently forced to stress bulk and cheapness rather than nourishment. Thus the hospital spends less money at the outset, but pays in loss of vitality throughout the whole institution, and that loss, written in terms of indifferent health and mediocre work, will add up to a large sum in dollars and cents at the end of the year. It is poor judgment to save on food. The thoughtful dietitian will avoid false economy in the selection of food for the nurses and staff. Certainly any hospital superintendent, if it were brought to his attention, would prefer an efficient and contented staff rather than a reduced food budget.

The adequate dietary in addition to sufficient total calories must supply the body's need for protein of good biologic value, the mineral constituents calcium, phosphorus and iron, without which normal metabolism is impossible, and also the vitamins A, B, C, D and E, which are necessary to prevent the development of pathologic symptoms. If any one of these essentials is lacking, or is inadequately supplied, the institutional meals are open to criticism because the health of the workers is impaired. When a dietitian learns that nurses and employees are continually buying food and candy she should take it as a severe criticism of the food she is serving, because a person adequately fed will not need to go out to buy.

An institutional dietary may be adequate in every respect and yet not sufficiently attractive or sufficiently appetizing to induce people to eat enough of it to nourish them. Contrasts in color, texture and flavor should be definitely planned for in every meal, while monotony and dullness are to be avoided. The flavor of foods is of great importance because of its bearing on digestion and should never fluctuate, and so the dietitian or an assistant should taste to know that the food she orders is correctly cooked, palatable and appetizingly served. Only by so doing can she maintain that high standard of food service which is so essential in a hospital.

Dr. Martin Emphasizes Needs of Standardization

Dr. Franklin H. Martin, director-general of the American College of Surgeons, addressing one of the largest assemblies of surgeons and hospital people on record at the Hospital Standardization Conference of the Clinical Congress of American College of Surgeons in Montreal, stated in part:

The American College of Surgeons greatly appreciates this opportunity of officially presenting to the people of the United States and Canada the list of approved hospitals of thirty-five beds and over. These hospitals have adopted the fundamental requirements for the right care of the patient and the broadest community service, as provided for in the minimum standard requirements laid down by the American College of Surgeons, an international organization charged with the responsibility of the great movement known as Hospital Standardization:

The right care of the patient comes first in every hospital. Years of investigation and study have proved to the American College of Surgeons that this can only be assured through the acceptance and carrying out of the principles as laid down in hospital standardization, embodied in which are the six great fundamental principles upon which rests our responsibility to the patient—organization, co-ordination, co-operation, efficiency, economy and service.

It is true that the hospital has become a part of the social life of our people. It is becoming increasingly used from day to day, and 12,000,000 or more persons are in hospital annually. The demands made on the hospital have increased correspondingly through the more discriminating public, the to-be nurse and the interne when choosing a hospital, and educational, financial and governmental organizations when seeking affiliations or financial support.

It is hardly conceivable that any community should be content with a hospital which has not been awarded this recognition as a public assurance that it fully recognizes its responsibility to the patient, the student nurse, the young doctor and the community at large, If every hospital in the United States and Canada were operated strictly under hospital standardization requirements, there would be at least a saving of 24,000,000 hospital days for the 12,000,000 patients as compared with conditions prevailing prior to 1918, when the hospital standardization movement commenced. Further, the hospital death rate under the same conditions would be reduced on the average 15 to 20 per cent. Both from the economic and humanitarian standpoints the citizens of two great countries cannot turn a deaf ear to this movement, and each community must assume the responsibility of seeing that its hospital is meeting the requirements and on the approved list.

Hospital standardization is a great responsibility, and it should appeal to everyone who is interested in the better care of the patient. The smaller hospitals have been seriously handicapped because the college has been unable, for financial reasons, to survey them

(*Continued on Page 26*)

News of Hospitals and Staffs

A Condensed Monthly Summary of Hospital Activities, Building and Extension Plans and Personal News of Hospital Workers.

HARRISTON, ONT.—The resignation of Miss R. Robinson, assistant superintendent of Mount Forest Hospital, has been accepted with regret by the Board. The position vacated is being taken by Miss Katie Selfert, of Harriston, who is a graduate nurse of St. Joseph's Hospital, Guelph.

* * *

NORTH BAY, ONT.—Miss Florence Quinlan, of the local hospital staff, whose marriage took place in October, was the guest of honor when Miss E. M. Rodgers, superintendent of the hospital, entertained at a bridge and miscellaneous shower at the Nurses' Residence in honor of the bride-elect.

* * *

VANCOUVER, B.C.—The Salvation Army is about to erect another "Grace Hospital" in Vancouver. A fine site in Shaughnessy Heights has already been donated by a public-spirited citizen, and part of the $130,000 required for the buildings and equipment has already been subscribed. Canvassers for about $50,000 still required will soon start work. Mr. W. J. Blake Wilson is chairman and Captain Glover is vice-chairman of an active committee of leading citizens who are assisting the Salvation Army to secure the money for this institution.

* * *

KENTVILLE, N.S.—Dr. Gerald R. Burns, of Halifax, has accepted a position on the medical staff of the Nova Scotia Sanatorium. He obtained his B.A. from St. Mary's College in 1920, and graduated from Dalhousie in medicine in 1925. He was a member of the staff of the Victoria General Hospital, Halifax, for two years. During his last year he was resident anaesthetist. Since June last he has been doing locum tenens in Cape Breton. He is filling the place recently made vacant by the resignation of Dr. Paul Young from the Sanatorium.

* * *

VANCOUVER, B.C.—For the first nine months of this year the Vancouver General Hospital has operated at a surplus of income over expenditure of $6,831. Had it not been for capital expenditure, the surplus would have been greater, this item alone accounting for $22,861.

Total income for September was $76,506, and expenditure $75,894. The capital account expenditure during the month was $6,475, leaving a deficit for the month's operations of $5,862.

The per capita cost for the month was $3.21 as against $3.14 for the corresponding period last year. The increase is principally due, according to the directors, to the employment of an additional seventy-five nurses, providing accommodation for them, and their maintenance.

ST. STEPHEN, N.B.—Another addition has been made to the permanent staff of The Chipman Memorial Hospital in the appointment of Miss Isabel Richardson, R.N., as night supervisor. She is a graduate of the General Public Hospital, St. John, and comes with an excellent record.

* * *

BARRIE, ONT.—The Medical Staff of the Royal Victoria Hospital held its annual meeting in the Hospital recently. Those present were Drs. E. G. Turnbull, W. A. Lewis, A. T. Little, V. Hart, L. J. Simpson and W. C. Little. Dr. Turnbull as retiring president occupied the chair, and Dr. W. C. Little as secretary. Dr. Norman Rogers was received as a member of the staff. The following officers were elected for the ensuing year: Pres., Dr. W. A. Lewis; Vice-Pres., Dr. G. B. Jamieson; Sec.-Treas., Dr. W. C. Little; Advisory Committee to the Hospital Board, Dr. Lewis, Dr. H. T. Arnall, Dr. A. T. Little, Dr. Simpson, Dr. Turnbull.

ORILLIA, ONT.—The fine new nurses' residence in connection with the Orillia Soldiers' Memorial Hospital was opened on Thursday, November 18th, with appropriate ceremonies. Invitations were sent out by the Board of Directors and Ladies' Auxiliary.

The building committee presented their report, after which the keys of the building were handed over to Miss Johnston, the superintendent.

* * *

REGINA.—Dr. M. R. Bow, superintendent of the General Hospital and City medical health officer, has tendered his resignation as superintendent of the General Hospital. Increased duties at the Hospital, it is understood, forced the decision of Dr. Bow either to continue as medical health officer or as superintendent of the General Hospital. The work it is claimed, has increased greatly during the past year and with the duties at the Hospital still growing, has become too heavy to be properly taken care of on a part-time basis as is now in effect.

* * *

ST. THOMAS, ONT.—The nurses at the Memorial Hospital were given a thrill recently, when a stranger was discovered in the sterilizing room of the operating department, and was captured by the nurses only after a long chase down and up stairs and through corridors.

The intruder was in the act of opening a case where morphine and other drugs are kept when the superintendent, Miss Armstrong, entered the room. He was taken to the police station, when he first gave the name of Wilkinson and later that of Sidney Sare, and his place of abode as Toronto.

* * *

ST. CATHARINES, ONT.—By an arrangement between the Board of Health and the Governors of the General Hospital, this city is to have a modern isolation hospital situated on Queenston Street to the east of the Nurses' Home. The hospital will accommodate at first twelve beds, and for the first time trained nurses will be employed for infectious cases. The former isolation hospital only took care of indigent patients and the accommodation was very meagre. The Board of Health will compensate the Hospital Board on a monthly basis for maintenance and capital outlay.

* * *

WINDSOR, ONT.—Essex county contractors only will be eligible to tender on the job of building the half million dollar Border Metropolitan Hospital.

This ruling, adopted by the Essex Border Utilities Commission, was advocated by Mayor F. J. Mitchell, one of the Windsor commissioners, who said it was not fair to allow outside firms to tender in the face of present industrial conditions, because of the large number of skilled and unskilled men at present out of work on the Border. The mayor voiced the fear that if a successful outside firm got the contract cheap labor could be brought in against the interests of local ratepayers who were helping to erect the hospital through taxes and private subscriptions.

Hospital Plumbing and Sanitation

By MEYER J. STURM, A.I.A.

Drinking Water Service

Where there is provision made for special drinking water service the faucets for drawing this water may be placed on certain designated fixtures throughout the building, but it has been found more practical and somewhat more convenient to install drinking fountains for this special purpose. Where drinking fountains are used they should be of the recessed type, and the faucets should be high enough or so arranged that a pitcher used in drawing water can be conveniently placed under them. Whether a bubbler is necessary must be decided by the authorities of the individual hospital in which this service is installed.

Operating room sinks should be vitreous or semi-vitreous, and should be provided with both "tap" and sterile water. Such sinks should be sufficiently large to permit two persons to wash at the same time. Use of floor drains in operating rooms is optional with the hospital administrators. There seems to be an equally divided opinion as to their necessity or usefulness. Doctors' wash-up rooms should be provided with lavatories, showers and water closets, as required by the size of the institution, the number of operating rooms, etc. Sterilizing room equipment should consist of a deep sink with integral dished drain boards and backs. These can be procured in either enameled iron or porcelain.

The main laundry should be provided with necessary gutter and floor drains, laundry tubs and toilet rooms. The toilets should be equipped with showers and dressing rooms in addition to the fixtures ordinarily installed in such rooms.

Choice of Fixtures

In general, the quality, kind and finish of fixtures must be left to the choice of the individual architect, or to the board, or to both, but there are certain considerations in hospital work which are not encountered ordinarily in other classes of buildings. One of these is that the hospital must be used constantly. There is no opportunity for making extended repairs or to shut down any one department for any length of time without crippling the entire service. If there were unlimited means, one could provide for such a contingency by putting in duplicate or at least more than a sufficient number of any one department or of fixture so as to adequately care for the needs of the institution. If, however, such an unnecessary procedure can be avoided by the simple expedient of installing the proper fixtures at the outset, it would be highly desirable that it be done.

In actual practice it has been found that all water closets should be, if possible, of the wall-hung type, equipped with flushing valves. Lavatories of the same material should also be of the wall-hung pattern. A good enameled iron tub will give practically endless wear, and now has an unlimited guarantee.

Scullery sinks should be made of metal. Such fixtures as slop sinks and ordinary sinks, including kitchen and diet kitchen sinks, if made of good enameled iron, will stand the test of wear and time. Unfortunately, large pieces cannot be made in vitreous china without being badly distorted. If it were not so this undoubtedly would be the ideal material for practically all of the plumbing fixtures in an institution.

GAS FITTING.—It is particularly desirable that the gas fitting in institutions should be carefully laid out. First, there should be such exit lights as are required by ordinances. Secondly, irrespective of what character of apparatus is to be used in certain departments, gas should be supplied and the requirements ascertained previous to the installation so that these supplies will be adequately large. This would include the piping to laboratories, service rooms, diet kitchens and main kitchens.

Emergency Measures

Emergency lights and outlets should be placed in at least one position in each of the so-called operating service departments of the institution and in a few selected locations in each corridor. A word as to these emergency lights will suffice. They should be placed without elaboration and with the utmost care to provide temporary light only.

Great care must be exercised in proportioning both horizontal and vertical runs. All turns or changes in directions of the piping should be made with long turn recessed fittings. Risers should be so placed and outlets provided that it will not be necessary to use a hose over fifty or seventy-five feet in length. This will preclude the possibility of the hose and process becoming too cumbersome. It is not the function of this article to describe the different plants, excepting to make the statement that the electrically-driven machine is preferable.

From an article published in Architectural Forum.

NEW BOOKS

COMMON PROCEDURES IN THE PRACTICE OF PAEDIATRICS, by Alan Brown, M.B., Physician-in-Chief to the Hospital for Sick Children, Toronto, and Frederick F. Tisdall, M.D., Attending Physician, Hospital for Sick Children, Toronto—McClelland and Stewart, Limited, Toronto. An important new work for doctors, students of medicine and nurses. It presents in detail the common procedures employed in the medical service of the Hospital for Sick Children.

There are eleven chapters, covering: Method of History Taking; Physical Examination; Infant Feeding; Pre-School and Adolescent Child; Diagnostic and Therapeutic Procedures; Parenteral Administration of Fluids; Eczema—Treatment; The Use of Biological Products in the Diagnosis and Treatment of Communicable Diseases; Difficultes in Diagnosis; Laboratory Methods; Drugs.

The methods described are of the greatest practical value to practitioner and student. All apparatus required and the actual steps of the different procedure have been described with great detail to make the work as practical as possible.

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Dr. Martin Emphasizes Needs of Standardization

(*Continued from Page 21*)

and give them the advice and assistance they so much desire. The college must continue its work among the larger hospitals, but must also endeavor in some way to finance the survey of the smaller institutions. Their importance in the United States and Canada is shown in the fact that the hospitals between 25 and 50-bed capacity, more than 1,500 in number, represent 47 per cent. of the total active hospitals, with beds aggregating 48,728. Many of these could easily qualify as approved hospitals The only reason they are not on this list is because of the increased expenses that would be incurred by the survey. This, as everyone connected with a hospital that is on the list can realize, is a tragedy that cannot be overestimated. Is there not someone, among the people of means interested in hospitals, who would be willing to finance this great work? The survey of the larger institutions must go on, with its considerable overhead that is already assumed and which would not be increased materially by the added cost necessary to visit the smaller hospitals. The college is in a position to do this additional work with the greatest economy and efficiency, having now the entire field set-up, if the means for financing the work are available.

In assuming the responsibility of providing a minimum standard for hospitals the American College of Surgeons fully realized that it was undertaking a task which would be of universal interest and benefit, based, as it was, on improving hospital service for the patient. This has happened. To-day every citizen of the United States and Canada is directly or indirectly benefiting from this movement. No task has given the Board of Regents more genuine satisfaction than carrying the standard into effect.

BELLEVILLE, ONT.—The General Hospital Board recently secured the services of Lorne Hawthorne, D.D.S., to take charge of the X-Ray department at the hospital and personally supervise all cases requiring X-Ray examinations. Dr. Hawthorne is a graduate in dentistry and has also had two years' study in medicine. He has made a specialty of X-Ray examinations and photography and may be said to be an expert in this department. He was four years with the United States Public Health Service in Chicago, in the X-Ray Department at the Jefferson Park Hospital, spent one year in X-Ray work in Peru, Illinois, and came here from Peterboro where he has been X-Ray examiner radiologist, for one and one-half years.

Dietetics in a Large Hospital

By ELIZABETH MILLER
Chief Dietitian, Philadelphia General Hospital,
Philadelphia, Pa.

Organization in a large city hospital such as the Philadelphia General is such a vastly different proposition from that which the majority of you represent that I scarcely know where to begin.

In the first place, we are large. We have every conceivable type of illness. We serve 9,000 meals daily. Being a city institution, we have some advantages and some disadvantages. We find that the best underlying principle of organization is in making the best of what we already have, then turning around and making that best still better.

The role of the dietitian is always a matter of much interest, so let me say right here that the head dietitian ranks with the heads of any other department in the Hospital and her assistants rank accordingly.

One of the great disadvantages in any big city-owned institution is in the material with which we must work either in the line of foods or of equipment. Much of this work is done through bids. Sometimes we get it and sometimes we do not. It is true we, as dietitians, hold the right to reject anything and we hold the right at least to specify what we would like to have.

Foods Served Hot

Our kitchens are so widely separated and each carries with it such a vast amount of work that it is necessary to have a graduate dietitian in charge of each kitchen. She plans her menus, looks after her kitchen and has the privilege of hiring her own help. In every case she follows up the serving of her meals. whether it be in the wards or in the dining room. All dietitians in the hospital are under the head dietitian.

The house, select and soft diets are all served from the hospital kitchen from which the food is sent out in large insulated boxes and wheeled directly into the ward. The trays are then set up and served direct from the food boxes. In this way only are we able to serve hot foods hot.

The dietitian in the metabolic department pays special attention to the most careful calculation and weighing of various foods for diabetic patients who are on a strict metabolic diet. This department is under direct supervision of Dr. Petty. These patients are separated from other patients and remain in a ward near the kitchen.

All other special diets as well as the diabetic diets in the wards and all special orders are prepared and sent out from the diet kitchen. Here also all preparation of food for the serving of trays to the sick nurses and doctors is made. We have served as many as forty trays from this kitchen. From eight to ten nurses are busy here all day long, working under the direct supervision of a graduate dietitian.

A housekeeper is in direct charge of the nurses' dining room. She carries out any instructions I may give and looks after things in general. I myself plan with her the menus for the nurses.

(*Continued on Next Page*)

From a paper read before the Hospital Dietetic Council, Atlantic City 1926.

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Another dietitian is in charge of the cafeteria and its kitchen where they feed five hundred employes three times daily. Since a dietitian was placed in charge here, the hospital has been able to serve a more appetizing meal at a saving of $1,000 a month.

I have one other assistant who does relief work when possible and who teaches the laboratory classes. I teach the theoretical work. To you it may not seem advisable to separate the teaching work, but at the present with us it is a necessity. The nurses all receive fifteen hours' lecture and thirty hours' laboratory work in their junior year and fifteen hours' lecture work on "diet in disease" in their intermediate year.

I want to tell you a little about the work we are giving our student nurses while they are in the diet kitchen. They come to us for a period of two months. All foods for special diets are prepared and sent from this kitchen. although the trays are not set up until the food reaches the wards. At first the nurse assists in the preparation of this food. Then she spends two weeks in preparing and serving the trays for the sick nurses, followed by two weeks in the metabolic department. We have just started to have her spend her remaining two weeks in working with and for definite patients with definite illnesses. She is assigned all diets of one type in a ward. For these few patients she plans her menus, prepares her food, takes it to the wards and serves directly to her patients. To date we find it quite successful. The nurse is much interested and I feel sure she is getting a great deal more than she did in her laboratory classes in "diet in disease." This work follows all her lecture work.

Course to Student Dietitians

Covering as we do so many phases of the work which a dietitian might be called upon to do, I feel that we can give a fairly well rounded course to our student dietitians. You may think they do not get enough private tray work. To overcome this we have them affiliate with the Presbyterian Hospital for a period of one week or longer if desired. This, with their trays for the sick nurses and those for the diabetic patients, gives them twelve weeks of actual work in preparing and serving trays. While in the metabolic department the students spend quite a little time in the clinic and in the laboratory where they see the tests for blood sugar and the urinalysis of those patients whom they have already learned to know. We believe in giving our students as much responsibility as possible and insist upon them relieving the dietitian in the department in which they are working.

There are just a few other matters to which I would like to call your attention.

All garbage is inspected and weighed as it comes from the department. If we average over twelve ounces per day per patient we hunt the cause and try to remedy it. Sometimes it is due to too heavy servings and sometimes to water in the garbage.

All requisitions for food supplies are sent to the diet kitchen and checked according to food allowances.

These orders are then given to the commissary to be filed.

We are working on a per capita cost basis in all departments but for various reasons, I am sorry to say, I do not feel it is what it should be.

I have chosen as far as possible only those things which seem to me essential in the organization of the dietary department in a large institution where the kitchens are widely separated.

OBITUARY

Henry Edward Webster

The Royal Victoria Hospital, Montreal, mourns its Superintendent, Henry Edward Webster, who died after a short illness at his residence in the hospital. Mr. Webster had served the hospital devotedly for over thirty years, eight years as assistant superintendent under J. J. Robson, then superintendent, and for twenty-two years as superintendent. He died in harness, having been engaged in his duties until within a few days of his death. He recently celebrated his fifty-third birthday.

"Mr. Webster's love for the hospital, his pride in it, and his desire to advance its usefulness in every possible way can never be forgotten by those who have been associated with him," said one of his colleagues. "No duty in the interests of the Royal Victoria Hospital was regarded by him as too exacting."

The late Mr. Webster was a prominent member of the congregation of Christ Church Cathedral, where he was a sidesman. He was a prominent Kiwanian, a member of the Sons of England, of the St. George's Society, and was connected with the Masonic Order.

Coming of medical stock—there had been a Dr. Webster of his family in his native place for over a century—Mr. Webster, though not himself a medical man, found in everything pertaining to the medical field his strongest interest. He was born in Golcar, Yorkshire, in 1873, and was the youngest son of the late Dr. Joseph Webster, of Golcar, and Mrs. Webster, formerly Miss Mary Smallhan. His brother was the late Dr. Alfred George Webster, of Golcar.

Mr. Webster was educated in England and came to Canada in 1893, coming straight to Montreal, where he worked in the woollen mill of his uncle, John Fisher. He remained at this work for two years, then went back to England for a year. On his return to Canada he entered the field which was nearest his heart and for which his talents fitted him, entering the service of the Royal Victoria Hospital in which he remained ever since.

$200,000 Gift to Montreal General

The Montreal General Hospital will benefit greatly through the generosity of the late Col. George R. Hooper, who died in Montreal on August 23rd. Colonel Hooper bequeathed $200,000 to the hospital.

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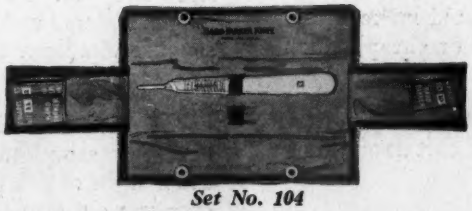

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